U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 22 October 2004

Case No.: 2003-BLA-6624

ORVAL KING,
Claimant,

v.

FLAT TOP COLLIERY CORP.,
Employer

and

WEST VIRGINIA COAL WORKERS' PNEUMOCONIOSIS FUND,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

John Cline,
for the Claimant

Robert Weinberger, Esq.
for the Employer/Carrier

Before: Michael P. Lesniak
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This case arises from a claim for benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. (Act), and applicable federal regulations, mainly 20 C.F.R. Parts 410, 718 and 725 (Regulations).

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was

caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

I held a formal hearing in this case on July 21, 2004 in Beckley, West Virginia. At the hearing, I afforded all parties a full opportunity to present evidence and argument, as provided in the Act and Regulations.[2] Claimant and Employer/Carrier filed a Joint Stipulation of Medical Evidence on August 18, 2004 and each filed a closing brief on September 13, 2004.

ISSUES

The contested issues are:

1) Whether Claimant has established a material change of condition pursuant to 20 C.F.R. § 725.309, and if so—
2) Whether Claimant has pneumoconiosis;
3) Whether his pneumoconiosis was caused by his coal-mine employment;
4) Whether Claimant is totally disabled; and
5) Whether his total disability is due to pneumoconiosis.

TR 8.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History [3]

The Claimant, Orval King, filed his first claim for benefits under the Act on January 6, 1980. DX-1. Although the record of that claim is not in the current case file, Claimant's attorney at a later hearing stated that the District Director denied benefits to Claimant in the 1980 claim on the basis that, although he had coal workers' pneumoconiosis (CWP), he was not totally disabled. DX-1.

Claimant filed his second claim for benefits on December 16, 1991. DX-1. After a claims examiner denied benefits on April 13, 1992, Claimant requested a hearing by letter on

---

[1] The following abbreviations are used in this opinion: DX = Director's exhibit, EX = Employer's/Carrier's exhibit, CX = Claimant's exhibit, TR = Transcript of the July 21, 2004 hearing, BCR = Board-certified radiologist, B = NIOSH-certified B-reader.

[2] At the hearing, I admitted Director's exhibits 1–29 and Claimant's exhibits 1–4 into evidence. At that time, Claimant withdrew from consideration as evidence the x-ray reading and qualifications of Dr. Gooding at CX-1. The trial transcript incorrectly states that only CX-1 and CX-2 were admitted.

[3] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (*i.e.*, March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in West Virginia, this claim arises within the territorial jurisdiction of the Court of Appeals for the Fourth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348 (10th Cir. 1998).

June 10, 1992. *Id*. After a hearing held on November 3, 1993, Administrative Law Judge (ALJ) Frederick D. Neusner issued a Decision & Order—Denying Benefits on January 31, 1994. *Id*. ALJ Neusner found that Claimant had pneumoconiosis caused by his coal mine work, but was not totally disabled. *Id*.

Claimant filed his third claim for benefits on February 2, 1995. The claim was denied by a claims examiner on July 17, 1995. DX-1. On March 29, 1996, the District Director issued a Memorandum of Informal Conference that affirmed the denial of benefits. *Id*. Following submission of additional evidence by Employer/Carrier, the District Director again affirmed the denial of benefits on April 15, 1996. *Id*. Claimant requested a hearing by letter on April 29, 1996. *Id*. After a hearing before ALJ James W. Kerr, Jr. on May 13, 1997, the ALJ issued a Decision & Order—Denying Benefits on October 1, 1997. *Id*. ALJ Kerr found that Claimant had not established a material change in condition because he did not show total disability. *Id*. Claimant requested reconsideration by letter dated October 28, 1997; ALJ Kerr denied this motion by Order dated January 13, 1998. *Id*.

All three of the above claims are administratively closed and not subject to adjudication. DX-29.

On January 26, 1999, Claimant filed a fourth claim for benefits. DX-2. No further information on this claim is present in the case file. Claimant filed for benefits again on July 13, 2001. DX-5. The claim was denied by District Director Robert Hardesty on June 13, 2003. DX-23. The Claimant requested a hearing by letter on June 23, 2003. The matter was referred to the Office of Administrative Law Judges on September 22, 2003. DX-25.

Applicable Regulations

At the July 21, 2004 hearing, the parties' representatives agreed that this claim should be evaluated under the revised ("new") Regulations that took effect in 2001. TR 5–6. However, under 20 C.F.R. § 725.309(b) (2001), the claim filed on July 13, 2001 must be merged with the "pending" claim filed on January 26, 1999. Nothing in the file suggests that the District Director ever took any action on the 1999 application; indeed, Claimant's representative contacted the District Director to confirm that the claim file was empty save the application itself. Claimant's Brief at n.2. The earlier application is therefore still pending, according to the Regulations, because it was never finally denied. 20 C.F.R. § 725.309(b). The Regulations mandate the merger of the 2001 claim with the pending 1999 claim, which in turn means that the case is subject the Regulations in effect in 1999. Contrary to the parties' stipulation, therefore, I find that this claim must be decided under the "old" regulations.

Duplicate Claim

Because more than a year has passed since the final denial of Claimant's most recent claim for benefits, the claim before me is considered a "duplicate" claim for benefits. 20 C.F.R. § 725.309. In *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996) (*en banc*), the Court of Appeals for the Fourth Circuit stated that "[t]he purpose of section 725.309(d) is not to allow a claimant to revisit an earlier denial of benefits, but rather only to show that his condition

has materially changed since the earlier denial." *Id*. at 406. The court concluded that it would apply the standard set forth by the Sixth Circuit Court of Appeals in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) for establishing a "material change in conditions." The *Sharondale* standard requires that the ALJ consider all of the new medical evidence and determine whether the claimant has proven at least one of the elements previously adjudicated against him. If the claimant is successful in this, then the ALJ considers all of the evidence to determine the claimant's eligibility for benefits.

In the current case, Claimant's prior claim for benefits was denied because he had failed to show total disability; he therefore also failed to show total disability due to pneumoconiosis. I will set forth below all of the medical evidence, then evaluate first whether Claimant has shown a material change in conditions with new evidence. If Claimant is successful in making this showing, then I will determine whether all the evidence shows that Claimant should be awarded benefits under the Act.

Claimant's Testimony

Claimant testified at the hearing on July 21, 2004. The relevant portions of his testimony follow:

Claimant was born October 20, 1915 and at the hearing was eighty-eight years old. TR 9. He is unmarried and has no dependents for purposes of this claim. TR 9.

Most of Claimant's coal-mine work was underground. TR 9. He began as a coal worker in 1934 and worked most years until 1980. TR 10. He began work as a coal loader, hand-loading coal, but progressed in his duties to become fire boss, section boss, mine foreman, and finally superintendent at the last plant where he worked. TR 10–12. Prior to starting work for Flat Top Colliery as mine superintendent in 1964, Claimant worked exclusively underground, in coal heights as low as twenty-eight inches and with no dust-control methods employed by the mines. *Id*. Claimant remained in his position with Flat Top Colliery until he stopped working in 1980; as he described the situation, he ran the day-to-day mining and his brother handled the business side of the operation in the office. TR 11–13.

When Claimant first began work as a superintendent, he regularly came up out of the mine itself for periods of time during his shift. TR 14–15. However, after a fatal accident in the mines that occurred about eighteen months into his tenure as superintendent, Claimant felt that his presence might prevent future accidents and began spending all of his shift time underground. *Id*. He worked with the people on his shift "as a team," performing any duties that needed to be done. TR 15–16. Claimant's primary job was hanging curtain to keep ventilation flowing at the face. TR 16. The job included drilling holes, inserting plugs with wires, and then lacing the wires into the curtain. TR 17. In performing other tasks that arose, Claimant repositioned timbers, pulled cable, and cleaned up coal on a daily basis, loading it into cars with a shovel. *Id*. On Saturdays, Claimant and the workers hauled fifty-pound bags of rock dust out of the storage area, into mine cars, and into the mine to be unloaded. TR 18–19. The Claimant rotated unloading duties among the workers (including himself) because he considered the work to be very strenuous. TR 20.

Claimant believes that he could no longer perform the work he did at his final job. TR 22. He explained that he could not do any of the physical duties, not even hanging curtain, which was his lightest duty. TR 21. "Physically I'm in fair shape for my age," he opined, "but I just don't have the lung power." TR 23. On a daily basis, Claimant exercises on a stationary bicycle for a total of forty minutes, plus he walks a mile on many days. TR 20–21. When exercising or walking, Claimant must stop frequently and rest in order to catch his breath. TR 21. Although he used to enjoy gardening, his breathing problems now preclude the activity completely. TR 23. In the past, Claimant's physician gave him breathing medicine, but Claimant found the medication unhelpful and no longer uses it. *Id*. He is not currently being treated for his shortness of breath and has never been hospitalized for breathing problems. TR 31–32. At this time, he takes medication for high blood pressure and thyroid problems. TR 33.

Claimant began smoking in fall 1934, at the age of eighteen, and smoked through his mid-forties. TR 24. He did not smoke very much in the 1930's because he had little money during the Depression to spend on cigarettes. TR 24. Claimant also explained that he smoked very little during World War II because cigarettes were rationed and "hard to come by." TR 24–25. After the war and until he was in his forties, Claimant smoked at home and never exceeded half a pack per day. TR 31.

Medical Evidence [4]

Chest X-rays

Exh.#	X-Ray Date	Physician/Qualifications	Interpretation
DX-1	8/4/80	Bassali/BCR, B	q, 6 zones, 2/2
DX-1	11/12/91	Yaeger	Nodules 2–3 mm throughout right lung field, more numerous in upper lobe. Scattered nodules in upper third of left lung field. Slight reticular pattern of interstitial lung markings in right lung field. Findings consistent with CWP.
DX-1	1/27/92	Speiden/BCR, B	q/p, 6 zones, 1/0
DX-1	1/27/92	Cole/BCR, B	No evidence of CWP
DX-1	1/27/92	Sargent/BCR, B	No evidence of CWP
DX-1	2/6/93	Bassali/BCR, B	p/q, 6 zones, 2/1
DX-1	9/16/93	Speiden/BCR, B	p/q, upper 4 zones, 1/0
DX-1	9/16/93	Leef/BCR, B	No evidence of CWP

[4] PFS and ABG results *in italic typeface* are the new medical evidence that I consider for the question of whether there has been a material change in Claimant's condition since the prior denial of benefits.

DX-1	4/10/95	Gaziano/B	No evidence of CWP
DX-1	4/10/95	Patel/BCR	p/p, 6 zones, 1/0
DX-1	4/10/95	Bassali/BCR	p/s, 6 zone, 1/0
DX-1	4/10/95	Spitz/BCR, B	No evidence of CWP
DX-1	4/10/95	Shipley/BCR, B	No evidence of CWP
DX-1	4/10/95	Wiot/BCR, B	No evidence of CWP
DX-1	4/17/96	Zaldivar/B	No evidence of CWP
DX-15	2/28/02	Patel/BCR, B	s/s, 6 zones, 1/0
DX-16	2/28/02	Binns/BCR, B	Quality reading only; quality 1
DX-22	2/28/02	Wiot/B	No evidence of CWP
CX-3	2/28/02	Rasmussen/B	s/t, 6 zones, 1/0
DX-21	12/4/02	Zaldivar/B	No evidence of CWP
CX-2	3/22/04	Alexander/BCR, B	p/p, 6 zones, 1/1

Pulmonary Function Studies[5]

Exh.#	**Date**	**Age**	**Height**	**FEV1**	**MVV**	**FVC**	**Qualify?**
DX-1	8/4/80	64	71"	2.92	152		No
DX-1	1/27/92	76	70.5"	2.45 2.93*	101 109*	3.98 3.92*	No No
DX-1	7/21/93	77	69.8"	2.56 2.51*	126.99 126.99*	4.08 3.98*	No No
DX-1	2/9/93	77	71"	2.25	100	3.9	No
DX-1	10/13/93	77	71"	2.00 2.35*	90	3.57 4.04*	No No
DX-1	4/10/95	79	70"	2.14 2.27*	99 116*	3.66 4.01*	No No
DX-1	4/17/96	80	71"	2.19 2.13*	77	4.06 4.04*	Yes Yes
DX-14	*9/13/02*	*86*	*70"*	*1.82* *1.98**	*68* *79**	*3.58* *3.71**	*Yes* *Yes*

[5] Values marked with an asterisk (*) are post-bronchodilator. Because of discrepancies in Claimant's recorded height, qualification is based on an average height of 70.5". For each PFS after 1980, because Claimant's age became significantly beyond those listed in the regulatory charts, I determined whether those tests produced qualifying values by calculating the FEV1-to-FVC ratio; values below 55 are considered evidence of disability under the Regulations. 20 C.F.R. § 718.204(b)(2)(i)(C).

DX-21	*12/4/02*	*87*	*71"*	*1.92* *2.02**		*3.87* *4.07**	*Yes* *Yes*
CX-1	*3/22/04*	*88*	*70"*	*1.52*		*3.10*	*Yes*

Arterial Blood Gas Studies [6]

Exh.#	**Date**	**PCO2**	**PO2**	**Qualify?**
DX-1	8/4/80	40 38*	77 92*	No No
DX-1	1/27/92	38 38*	72 70*	No No
DX-1	10/13/93	39	73	No
DX-1	4/10/95	38 38*	75 69*	No No
DX-12	*2/28/02*	*43* *43**	*61* *54**	*No* *Yes*
DX-21	*12/4/02*	*41*	*76*	*No*

I note that the pre-exercise ABG result on 2/28/02 was very close to qualifying under the Regulations.

Medical Reports

Ida Z. Villanueva, 8/4/80

Dr. Villanueva examined Claimant at the request of the Department of Labor (DOL) and submitted a report that appears in evidence at DX-1. The physician recorded a personal medical history of arthritis, high blood pressure, and emphysema in the Claimant. He reported having smoked for about five years at one-third to one-half pack per day, stopping in 1950. Claimant's chief complaint was shortness of breath that limited walking to 300 feet, climbing to twenty stairs, lifting to 100 pounds, and carrying fifty pounds of weight for 100 feet. On physical examination of the Claimant, Dr. Villanueva had no remarkable findings.

The physician diagnosed Claimant with pneumoconiosis and chronic obstructive pulmonary disease (COPD), citing as evidence x-ray findings positive for the disease. Dr. Villanueva responded both "yes" and "no" when asked whether Claimant's conditions were caused by his coal-mine dust exposure. The physician also noted that there was no objective evidence of significant pulmonary dysfunction in the Claimant.

[6] An asterisk (*) indicates a post-exercise result.

Thomas O. Dotson, 11/13/91

Claimant went to the Greenbriar Clinic for a two-day complete physical exam; the examining physician, Dr. Dotson, submitted a report that appears in evidence at DX-1. Dr. Dotson noted that he was evaluating several complaints including hypertension and shortness of breath that occurred in the Claimant while he was gardening. At that time, Claimant reported that he played golf almost daily as well as doing gardening and yard work. Dr. Dotson's physical examination of Claimant revealed no significant findings.

The physician consulted an x-ray that had been read as consistent with pneumoconiosis; he also consulted the results of objective testing including pulmonary function studies (PFS) and arterial blood gas (ABG) studies. Dr. Dotson found that the PFS showed an obstructive defect. He diagnosed several conditions in the Claimant including vascular hypertension, a right carotid artery bruit secondary to atherosclerotic obstruction, and CWP based on positive x-ray findings.

Donald L. Rasmussen, 1/27/92

Dr. Rasmussen, who is Board-certified in internal medicine and pulmonary disease, examined Claimant at the request of the DOL and wrote a report dated 1/27/92 that is in evidence at DX-1. He recorded Claimant's coal-mine employment as being forty-four years in duration, ending in 1980, with his last job as a mine manager involving much crawling, setting timbers, rock dusting, unloading supplies, and performing some heavy manual labor. Claimant's personal medical history was positive for arthritis of the fingers and high blood pressure. Dr. Rasmussen recorded Claimant's smoking history as spanning from 1932–1945 at one-quarter pack per day.

Claimant presented to Dr. Rasmussen with complaints of daily minimal sputum production with cough in the morning, wheezing at night, dyspnea that occurred upon using his garden cultivator, left anterior chest pain with exertion, and minimal orthopnea. Upon physical examination, the physician found Claimant's breath sounds to be moderately to markedly decreased with no rales, rhonchi or wheezes. Dr. Rasmussen also found an increased expiratory phase with forced respiration and an aortic systolic murmur.

Dr. Rasmussen consulted an x-ray showing CWP, a PFS showing a minimal irreversible obstructive ventilatory impairment, an ABG showing minimal impairment in oxygen transfer during exercise, and a moderately decreased SBDLCO (single-breath carbon-monoxide diffusing capacity) with normal DL/VA. The physician diagnosed CWP based on positive x-ray findings and forty-four years of coal-mine employment, and caused by the coal-mine employment. He also diagnosed chronic bronchitis based on Claimant's history of chronic productive cough; this condition too was caused by coal-mine employment. Dr. Rasmussen further found that Claimant had a minimal pulmonary impairment that would not prevent his returning to his previous coal-mine employment. Finally, the physician stated that Claimant's impairment was caused "primarily" by coal-mine dust exposure.

Donald L. Rasmussen, 4/3/92

Dr. Rasmussen filed a supplemental report in response to a letter from the District Director regarding the results of the 1/27/92 x-ray. The physician responded to the District Director's concern that well-qualified physicians had read the film very disparately, with some finding evidence of pneumoconiosis while others found none. Dr. Rasmussen stated that disagreements among well-qualified physicians in interpreting chest x-rays is usual, for the reason that a chest x-ray is a "relatively insensitive tool" for detecting the disease. Dr. Rasmussen examined the re-read reports on the x-ray and stated that his own interpretation of the film (positive for pneumoconiosis) did not change.

Donald L. Rasmussen, 7/21/93

Dr. Rasmussen examined the Claimant and submitted a report dated 7/21/93 that appears in evidence at DX-1. Claimant reported his coal-mine employment history as lasting forty-four years, during which most of his time was spent at the face. His last job was frequently underground work, including loading and unloading supplies, setting timber, and shoveling; Dr. Rasmussen described the work as "including heavy manual labor." Claimant's last employment was in 1980. Claimant reported having smoked from 1942 to 1963 at a rate of one-third to one-half a pack per day.

Claimant's chief complaints were shortness of breath upon exertion that had persisted for ten years and occurred while doing even light gardening work, wheezing at night, and upper anterior chest pain upon exertion. Dr. Rasmussen performed a physical examination of Claimant and found breath sounds to be minimally reduced, with a few fine inspiratory rales at the lateral bases. The physician also detected reduced heart tones and a systolic murmur.

Dr. Rasmussen consulted an x-ray that had been read as p/q, 2/1. He also consulted the results of a PFS, which showed a minimal irreversible obstructive defect with minimally reduced MVV and minimally reduced SBDLCO. The electrocardiogram showed normal results aside from sinus brachycardia. The physician noted that the miner's resting ABG values were normal, while the post-exercise results showed minimally reduced oxygen transfer and minimal hypoxia.

Dr. Rasmussen diagnosed the Claimant to have minimal loss of respiratory function as shown by his ventilatory impairment, reduced diffusing capacity, and post-exercise oxygen-transfer impairment. He also diagnosed the Claimant with CWP based on the x-ray changes and a compatible coal-mining work history. Both these conditions the physician attributed to coal-mine dust exposure. In addition, the Claimant's respiratory diagnosis showed him to be completely disabled from performing the duties of his last coal-mine work. Dr. Rasmussen noted that Claimant's minimal, remote smoking history "may have contributed to a mild degree" to his impaired respiratory function.

Thomas O. Dotson, 9/17/93

Claimant presented himself for another two-day evaluation at the Greenbriar Clinic in September of 1993; the examining physician, Dr. Dotson, submitted a report that appears at DX-

1. The physician again noted the Claimant's coal-mine work history as lasting forty-four years, with his last job spanning seventeen years and involving heavy physical labor.

The Claimant's chief complaint was shortness of breath that occurred when he walked up an incline, when he walked one-quarter of a mile at no grade, when pulling his golf cart uphill or quickly, and particularly when gardening — "it recently took him six hours to dig up two rows of potatoes." Claimant reported no chronic cough, although he said his wife hears him wheeze at night. He was continuing daily activity, walking slowly more than two miles daily, doing some gardening and yard work, and playing golf weekly.

Upon physical examination, Dr. Dotson found the Claimant to have slightly distant breath sounds with no rales or rhonchi. He consulted the results of an electrocardiogram (normal), an x-ray (positive for pneumoconiosis, p/q, 1/0), and the previous Greenbriar Clinic exam in 1991. Dr. Dotson diagnosed a mild obstructive defect and minimal changes of CWP by x-ray. He found the Claimant to be totally disabled from his previous coal-mine job because of his inability to perform any strenuous activity. Finally, Dr. Dotson noted that Claimant's blood pressure was satisfactorily being controlled by medication.

Robert J. Crisalli, 11/2/93

Dr. Crisalli examined the Claimant and submitted a report dated 11/2/93 that appears in evidence at DX-1. He recorded Claimant's coal-mine employment history as lasting more than forty years and ending in 1980, Claimant having worked for the last seventeen years as a superintendent. Dr. Crisalli noted Claimant's duties as having included medium to heavy manual labor, including timbering, rock dusting, shoveling coal, and operating a continuous miner.

Claimant's complaints were dyspnea that occurred when working in his garden, climbing hills or mowing his lawn with his riding mower. Claimant reported a cough productive of sputum for more than three months out of each year for the past several years, especially in the winter months. He also reported orthopnea that had lasted for twelve years. Dr. Crisalli examined Claimant and had no significant findings except for detecting a left carotid bruit.

Dr. Crisalli consulted an x-ray that a well-qualified physician had interpreted as negative for pneumoconiosis; Dr. Crisalli read the x-ray himself and agreed with this interpretation. He also recorded that a PFS showed a mild airflow obstruction with significant response to bronchodilators. Dr. Crisalli noted that Claimant's resting ABG results were normal, although no exercise was performed because of carotid occlusive disease. Finally, the physician consulted the previous reports in Claimant's Black Lung benefits record.

Dr. Crisalli diagnosed the following conditions in Claimant: asthmatic bronchitis, based on his history of productive cough and the PFS results showing a significantly reversible mild obstructive defect; hypertension, based on Claimant's history; carotid artery disease, based on Claimant's history; and radiographic abnormalities of dilated aorta and transposition of colon, based on x-ray. The physician went on to explain that the widened aorta was unrelated to a pulmonary impairment, CWP or coal-dust exposure. Dr. Crisalli found that Claimant had no

CWP or any pulmonary impairment attributable to coal-mine employment. The physician diagnosed a 5–10% ("minimal") pulmonary impairment from asthmatic bronchitis.

Donald L. Rasmussen, 4/10/95

Dr. Rasmussen performed another evaluation of the Claimant at the request of the DOL and wrote a report dated 4/10/95 that appears in evidence at DX-1. He recorded that Claimant's last coal-mine employment was as a superintendent, a job involving heavy labor, and that it ended in 1980. Claimant reported that he had never smoked regularly. The physician recorded a personal medical history of arthritis in hands and knees, a possibly cancerous tumor, and high blood pressure for which Claimant was taking medication.

Claimant presented to Dr. Rasmussen with complaints of nightly wheezing, dyspnea upon carrying small armloads of firewood into the house, and two-pillow orthopnea. The physician examined Claimant and found his breath sounds to be markedly decreased on auscultation, with no rales, rhonchi, or wheezes. Dr. Rasmussen consulted an x-ray that showed pneumoconiosis p/p, 1/0, as well as a PFS showing a moderate irreversible obstructive ventilatory impairment, an ABG showing minimal impairment in oxygen transfer post-exercise, and a minimally reduced SBDLCO with normal DL/VA.

Dr. Rasmussen diagnosed CWP in the Claimant, based on his coal-mine employment history and x-ray evidence. This disease, the physician stated, was caused by coal mine dust exposure. In addition, Dr. Rasmussen diagnosed COPD based on Claimant's chronic airflow obstruction; that disease was also caused by coal-mine employment. As for disability, the physician explained that:

> The patient's anaerobic threshold … indicates a limited steady working capacity. As a consequence of his pulmonary disease, this patient is totally disabled for performing heavy manual labor. He is, therefore, totally disabled for resuming his former coal mine employment with its attendant requirement for heavy manual labor. The primary risk factor for the patient's disabling respiratory insufficiency is his coal mine dust exposure with its resultant pneumoconiosis.

George L. Zaldivar, 4/30/96

Dr. Zaldivar, who is Board-certified in internal medicine, pulmonary diseases, sleep disorder medicine, and critical-care medicine, examined the Claimant and submitted a report dated 4/30/96 that appears in evidence at DX-1. Dr. Zaldivar recorded Claimant's work history as including forty years of coal-mine work that ended in 1980 when Claimant's wife became ill. For the last seventeen years, Claimant managed a mine and his duties included hanging curtain and rock dusting (both by hand and with a rock duster). Claimant reported that he had smoked one-third of a pack of cigarettes per day for about ten years, quitting approximately fifty years ago.

Claimant reported that his chief complaint was shortness of breath that occurred upon gardening or walking uphill. He also reported wheezing at night and two-pillow orthopnea. On

physical exam, Dr. Zaldivar heard mild systolic murmurs but had no other remarkable findings. Dr. Zaldivar read an x-ray showing no pneumoconiotic changes and noted that the PFS showed mild irreversible airway obstruction and low diffusing capacity, with normal lung volumes. Finally, the physician noted nonspecific changes in the electrocardiogram.

Dr. Zaldivar diagnosed no CWP in the Claimant, based on a negative x-ray, Claimant's medical history, and the physical exam and physiological abnormalities of the Claimant. The physician diagnosed mild airway obstruction and low diffusing capacity, stating that the pulmonary impairment was non-occupational and is not severe enough to disable Claimant from performing his last coal-mine work. Dr. Zaldivar provided no explanation for the abnormal PFS results.

Jeffrey E. Weiland, 4/14/97

Dr. Weiland, who is Board-certified in internal and pulmonary medicine and is a medical examiner, consulted the reports contained in Claimant's Black Lung benefits file and provided a report dated 4/14/97 that appears in evidence at DX-1. Dr. Weiland concluded that Claimant did not have CWP, based on the medical findings in the reports. He also found that Claimant did not have any pulmonary impairment attributable to his coal-mine employment. From a pulmonary standpoint, Dr. Weiland opined that Claimant was not disabled and could perform his last coal-mine job. The physician's main findings were moderate obstructive airways disease with a mild diffusion impairment and minor arterial oxygen desaturation with exercise. Dr. Weiland characterized these findings as inconsistent with pneumoconiosis but consistent with advanced aging. The physician called Claimant's smoking history "trivial."

Donald L. Rasmussen, 2/28/02

Dr. Rasmussen examined Claimant at the request of the DOL and submitted a report that is in the record at DX-11. The Claimant reported his coal-mine working history as lasting from 1934–1980, finally as a superintendent who usually worked underground. Dr. Rasmussen recorded Claimant's job duties as including walking and crawling in twenty-eight- to thirty-inch coal, hanging curtain, and pulling heavy electrical cable; the physician classified the work as having "some heavy manual labor." The Claimant said that he had never smoked regularly, and that he had a medical history positive for arthritis in the fingers, bladder cancer in 1997, and high blood pressure for many years.

Claimant reported having wheezing and dyspnea for many years, as well as two-pillow orthopnea. The shortness of breath occurred upon walking up any grade. Dr. Rasmussen examined Claimant and found his breath sounds to be markedly reduced on both sides. Claimant's heart sounds were also reduced, and the physician found a right systolic carotid bruit. Dr. Rasmussen consulted an x-ray that showed pneumoconiosis s/s, 1/0, as well as a PFS that showed moderate, irreversible obstructive ventilatory impairment. The physician noted that the ABG showed marked impairment to oxygen transfer. He also recorded a moderately to markedly reduced SBDLCO.

Dr. Rasmussen diagnosed CWP based on Claimant's coal-mine work history and the x-ray evidence; the physician identified the etiology as coal mine dust exposure. He further diagnosed COPD/emphysema, based on the airflow obstruction and reduced SBDLCO; that disease was also attributed to occupational coal-dust exposure. Dr. Rasmussen found that Claimant had a "marked loss of lung function," so that he did not "retain the pulmonary capacity to perform his last regular coal mine job." The physician further explained that exposure to coal mine dust had caused Claimant's obstructive airways disease and parenchymal lung disease, as demonstrated by the impairment in oxygen transfer with exercise and the reduced SBDLCO.

George L. Zaldivar, 1/6/03

Dr. Zaldivar examined the Claimant and submitted a report that appears in evidence at DX-21. The physician recorded Claimant's last coal-mine work as "manager," although Claimant spent all of his time in the mines performing duties such as rock dusting, shoveling, operating the miner, and pulling cable. Dr. Zaldivar noted that he recorded Claimant's smoking history as spanning four years and ending fifty years ago, while his technician recorded it as spanning fifty years and ending four years ago. The physician stated that, even if the former were the case, the Claimant would have been forty-seven years old when he quit, which would have given his habit enough time to cause some damage in his lungs that would slowly progress with age.

Claimant's complaints upon examination were shortness of breath that occurred when walking 200 feet on an incline. He had an occasional cough that he said was due to a current cold, and he said that his wife had told him he wheezed at night. Claimant also reported two-pillow orthopnea. Dr. Zaldivar stated that a physical exam produced no significant findings. He consulted the results of a PFS that showed a mild irreversible obstruction, air trapping by lung volumes, and a mild diffusion impairment. The physician interpreted Claimant's x-ray as completely negative for pneumoconiosis. Finally, Claimant's ABG showed mild resting hypoxemia.

Dr. Zaldivar concluded that Claimant did not have x-ray evidence of CWP. He stated that CWP might be present in the lungs despite its absence on x-ray, but "the dust burden of the lungs must be extremely low since there is no visible reaction that could have resulted in airway damage." As for Claimant's PFS results, Dr. Zaldivar opined that they might in fact be normal for a man of Claimant's advanced age, as he knew of few results for comparison. Dr. Zaldivar also suggested that Claimant's mild abnormality in his breathing capacity could be due to his past smoking habit, as that damage would slowly progress with age but would not be visible on an x-ray. The physician found that Claimant is able to perform his last coal-mine employment, from a pulmonary standpoint, although his age and deconditioning disable him as a "whole man" from doing the work.

Thomas O. Dotson, 3/23/04

Claimant had his annual two-day examination at the Greenbriar Clinic in March 2004 with Dr. Dotson, whose report is in evidence at CX-1. Dr. Dotson consulted Claimant's past evaluation records from the Clinic, where he had been treating Claimant since September of

1991. Claimant reiterated his work history as forty-four years of coal-mine employment, with the last seventeen years including "vigorous physical work at times."

Claimant's complaints at his examination included shortness of breath upon doing physical work such as cutting grass (requiring frequent stops for rest), upon walking one-quarter of a mile at no grade, and upon walking any distance at an incline (requiring three or four stops in a quarter-mile walk). Dr. Dotson recounted Claimant's history of carotid artery blockage, for which he had surgery in 1991 and for which Dr. Dotson has continued to evaluate him. Upon physical examination, Dr. Dotson found Claimant's breath sounds to be slightly distant, with no rales or rhonchi. The physician consulted new objective testing results including an x-ray that showed pneumoconiosis and a PFS that showed an obstructive defect.

Dr. Dotson reiterated his diagnoses of CWP based on x-ray findings and a compatible work history, as well as a mild obstructive defect based on PFS; both disorders were identified as arising from coal-mine dust exposure. In addition, Dr. Dotson noted that Claimant's carotid bruits and high blood pressure remained under control with treatment. The physician gave Claimant an Advair sample to try using prior to exercise.

Donald L. Rasmussen, 6/7/04

The supplemental report of Dr. Rasmussen appears in evidence at CX-3. He consulted the Claimant's previous DOL exams as well as Dr. Zaldivar's 12/4/02 exam report. Dr. Rasmussen summarized Claimant's coal-mine employment history as covering about forty-six years, much of it prior to the use of dust suppression in the mines. The physician also described Claimant's smoking history as "minimal," lasting for up to twenty years at up to half a pack per day (except that Dr. Zaldivar's technician had recorded a much longer history that was inconsistent with all other smoking histories related by Claimant). Dr. Rasmussen characterized Claimant's smoking history as "minimal and remote," although even if Claimant's smoking history were more extensive, Dr. Rasmussen stated that his conclusions regarding Claimant's condition would not change.

Dr. Rasmussen observed that x-ray interpretations of Claimant's films have been "mixed," with both positive and negative readings. The physician opined that such a mix of readings is normal for patients with low-profusion CWP nodules. He went on to cite studies linking pneumoconiosis with higher occurrence rates of emphysema, diffuse interstitial fibrosis, and reduction of single-breath carbon-monoxide diffusion capacity.

The physician next observed that Claimant has had a "mild, progressive reduction in FEV1 percent predicted" from 1991 to 2002. The Claimant's gas-exchange studies have been abnormal as well, with the abnormality increasing significantly from 1995 to 2002. "This degree of impairment," Dr. Rasmussen concluded, "clearly precludes Mr. King's performance of his last regular coal mine job, which required heavy manual labor."

Dr. Rasmussen took issue with Dr. Zaldivar's statement that Claimant's reduced spirometry values might be normal for his age, although a lack of individuals available to provide comparable rates makes certainty difficult. Dr. Rasmussen reported that he himself has

examined "a significant number of gentlemen around age 90, most of whom exhibited entirely normal or better than supposed normal [values] for their age." Based on this knowledge, Dr. Rasmussen was confident that Claimant's test values were not normal for his age, but instead were reduced.

Dr. Rasmussen also responded to Dr. Zaldivar's statement that Claimant's negative x-ray results preclude the possibility that his lungs retain sufficient dust to cause lung tissue damage. Dr. Rasmussen stated that x-rays are "a very poor tool for assessing pulmonary functional status." He contended that even patients with extensive simple or complicated CWP findings on x-ray might still have "essentially normal lung function" on PFS. He cited studies to support this conclusion.

Finally, Dr. Rasmussen disagreed with Dr. Weiland's findings that Claimant's symptoms are inconsistent with CWP. To the contrary, Dr. Rasmussen stated that Claimant's impairment pattern is consistent with documented CWP, "namely significant impairment in oxygen transfer absent significant airway obstruction." Dr. Rasmussen cited to medical articles to support his conclusions.

Dr. Rasmussen concluded his supplemental report by once again drawing on the Claimant's medical evidence to find that he had CWP caused by his coal-mine employment and that the disease has left him totally disabled from performing his last job.

Robert A.C. Cohen, 6/18/04

Dr. Cohen reviewed Claimant's examination reports from 1/6/03 (Dr. Zaldivar), 12/4/02 (Dr. Zaldivar) and 2/28/02 (Dr. Rasmussen) and wrote a consultation report that appears in evidence at CX-4. Dr. Cohen is a B-reader and is Board-certified in radiology and internal medicine. He has also published numerous articles regarding occupational lung diseases.

The physician summarized the Claimant's work history as spanning forty-two years, with his last job as superintendent involving walking and crawling in low coal seams, hanging curtain, and pulling heavy cables. Although accounts of Claimant's smoking history vary, Dr. Cohen concluded that they indicate a total of about six pack years, ending in the 1940's. The physician noted that Dr. Zaldivar's technician recorded a much longer smoking history. Dr. Cohen described Claimant's smoking history as minimal.

Dr. Cohen diagnosed Claimant with CWP that is substantially related to his occupational coal-dust exposure. He called the contribution of smoking to Claimant's disease "minimal." The physician based his CWP diagnosis on Claimant's symptoms of chronic lung disease including progressively worse shortness of breath, on findings of decreased air entry upon examination, on PFS values showing a moderate obstructive defect with diffusion impairment, on ABG post-exercise values showing significant hypoxemia and gas exchange abnormality, on positive chest x-rays, and on no other patient-reported occupational exposures. Even absent the x-ray findings, Dr. Cohen stated, he would continue to diagnose Claimant with CWP based on these other findings, all of which are consistent with CWP.

Further, Dr. Cohen diagnosed Claimant with COPD. The obstructive lung disease was shown by PFS values (namely, severely reduced FEV1-to-FVC ratios). The physician stated that "obstructive disease from coal mine dust can occur in the presence or absence" of CWP nodules on x-ray. To support his position, Dr. Cohen described and cited NIOSH studies and later supportive study findings linking coal-mine dust exposure to obstructive disease and emphysema. The physician further concluded that Claimant's occupational exposure was a significant contributing cause of his obstructive lung disease.

Finally, Dr. Cohen expressed his opinion regarding Claimant's disability. The physician found that Claimant's moderate obstructive lung disease with diffusion impairment, as well as his significant gas exchange abnormality with exercise, disables him completely from his former work duties. Dr. Cohen attributed the disabling COPD to coal mine dust exposure, with Claimant's smoking making a "minimal contribution" to the disease.

Other Medical Evidence

West Virginia Occupational Pneumoconiosis Board, 2/9/93

Included in the record at DX-1 are the findings of the West Virginia Occupational Pneumoconiosis Board, which examined Claimant's medical records and determined that he suffers from CWP and that he has a 40% functional impairment attributable to the disease.

Standard of Review

As the ALJ, I need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw my own conclusions and inferences. *See Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989). The ALJ's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty; Fagg v. Amax Coal Co.*, 12 B.L.R. 1-77 (1988), *aff'd*, 865 F.2d 916 (7th Cir. 1989).

In considering the medical evidence of record, an ALJ must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984). The weight of the evidence and determinations concerning credibility of medical experts and witnesses, however, is for the ALJ. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985).

As the trier of fact, the ALJ has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the ALJ must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Material Change in Condition

Pursuant to 20 C.F.R. § 725.309(d) and *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996) (*en banc*), Claimant must prove an element of eligibility for benefits that was adjudicated against him in the previous claim in order to avoid dismissal of this claim. I therefore examine the new evidence to determine whether Claimant has shown total disability caused by pneumoconiosis. Total disability is defined as pneumoconiosis preventing a miner from performing his usual coal mine employment or other gainful work. 20 C.F.R. §§ 718.305(c), 718.204(b)(1). Section 718.204 sets out the standards for determining total disability.

The Claimant's first option for demonstrating total disability is through pulmonary function study evidence. 20 C.F.R. § 718.204(b)(2)(i). Of the three pulmonary function studies submitted as new evidence, all produced FEV1-to-FVC ratios that demonstrate disability under the Regulations. Claimant has therefore provided qualifying evidence to establish disability. As there is no contrary probative evidence, I find that the pulmonary testing shows that Claimant is totally disabled from a pulmonary standpoint.

The Claimant can also demonstrate total disability with qualifying blood-gas study results. 20 C.F.R. § 718.204(b)(2)(ii). Of the two ABG studies that are new evidence, one produced a near-qualifying pre-exercise value and a qualifying post-exercise value. The other ABG study included only a pre-exercise value; it was non-qualifying under the Regulations. On balance, I find that the evidence of disability by ABG evidence outweighs the contrary probative evidence. Claimant has therefore shown that he is totally disabled by blood-gas study results.

The third method that Claimant can use to show total disability is by presenting evidence that he suffers from cor pulmonale with right-sided congestive heart failure. 20 C.F.R. § 718.204(b)(2)(iii). Because Claimant has produced no evidence that he suffers from this condition, I find that he has not shown disability by this method.

The fourth and final means for Claimant to demonstrate total disability is by the reasoned conclusion of a physician. The physician must exercise reasoned medical judgment based on medically acceptable clinical and laboratory diagnostic techniques in arriving at the conclusion that the Claimant's respiratory or pulmonary condition prevents him from engaging in his last or comparable employment. 20 C.F.R. § 718.204(b)(2)(iv). Among the new evidence in this claim are reports from four physicians: Drs. Rasmussen (DX-11; CX-3), Zaldivar (DX-21), Cohen (CX-4) and Dotson (CX-1). All of their reports—five in all—found that the Claimant is totally disabled from returning to his former job. However, one report (that of Dr. Zaldivar) concluded that Claimant's disability is due to age and deconditioning, rather than CWP as the other reports found.

In his report, although Dr. Zaldivar consulted the results of pulmonary function studies, he did not satisfactorily address those results in his conclusion that Claimant is not disabled from a pulmonary standpoint. In particular, Dr. Zaldivar discounted the PFS results because he stated that they "may be normal" for Claimant's age. Further, the physician concluded that, if the results were indeed abnormal, then the obstruction was caused entirely by Claimant's past

smoking habit. I found neither of Dr. Zaldivar's explanations convincing: Dr. Rasmussen confirmed that people of Claimant's age can produce PFS results within the ranges considered normal, and Dr. Zaldivar failed to explain how Claimant's extensive coal-dust exposure made no contribution to the obstructive defect. Because Dr. Zaldivar did not base his conclusions about Claimant's disability on the relevant test results (or, in his alternative explanation, on a reasoned elimination of other risk factors), I find that his conclusions on this issue were neither well-documented nor well-reasoned. I give his opinion little weight in my consideration of Claimant's disability.

The remaining four reports are both documented and reasoned. I give great weight to Dr. Rasmussen's reports on the basis of their particularly logical and convincing interpretations of the objective evidence. Dr. Cohen's report is entitled to added weight because of his outstanding credentials and well-reasoned explanations relating the evidence to his conclusions. Finally, Dr. Dotson's opinion is entitled to added weight because he has had the advantage of examining Claimant annually for over ten years, giving him particular insight into Claimant's current condition. *See Grigg v. Director, OWCP*, 28 F.3d 416 (4th Cir. 1994).

In sum, the medical reports of evidence overwhelmingly support a finding that Claimant is totally disabled from a pulmonary standpoint from doing his previous or similar work, and that this disability is caused by CWP.

As Claimant has demonstrated through PFS results, ABG studies, and medical reports that he is totally disabled under the definition of the Act and Regulations, I find that he has shown disability by a preponderance of the evidence pursuant to 20 C.F.R. § 718.204. He has therefore demonstrated a change in condition pursuant to 20 C.F.R. § 725.309(d) and *Lisa Lee Mines*. On that basis, I will consider all the evidence to determine whether Claimant is entitled to benefits under the Act.

Length of Coal Mine Employment

At the hearing, Employer/Carrier stipulated to forty-two years of qualifying coal-mine employment by the Claimant. TR 7. Claimant, on the other hand, deferred to an earlier ALJ's finding that Claimant was a coal miner for forty years and ten months. TR 8. Based on all the evidence, particularly the Claimant's Social Security Administration records, I find that Claimant was a coal miner within the meaning of the Act for forty-four years. DX-7.

Date of Filing

The parties stipulated at the hearing that this claim was filed on July 13, 2001. TR 5. However, as I explained above, I find that the 2001 claim is merged with the earlier claim that was pending since its filing in 1999. I therefore find that this claim was filed on January 26, 1999.

Responsible Operator

The parties have stipulated and I find that Flat Top Colliery Corporation is the responsible operator in this claim. TR 7.

Dependents

Claimant testified at his hearing that he is currently unmarried and has no dependents. TR 9. There is no contrary evidence in the record. I therefore find that Claimant has no dependents for purposes of augmentation of benefits under the Act.

Entitlement: In General

To establish entitlement to benefits, Claimant must establish that he has pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis.

Existence of Pneumoconiosis

Section 718.202 provides that the existence of pneumoconiosis can be established by chest x-ray, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis as defined in § 718.201.[7] 20 C.F.R. § 781.202(a)(1)–(4). All types of relevant evidence must be weighed together under § 718.202(a) in assessing whether the miner suffers from pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th. Cir. 2000).

Chest x-ray Evidence

When an ALJ considers x-ray evidence, the interpretations of physicians who are dually qualified (as Board-certified radiologists and NIOSH B-readers) are entitled to the greatest weight. The Benefits Review Board has held that it is proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999).

In all, there are twenty-one interpretations of ten separate x-rays in evidence. I observe that the films date all the way back to 1980 and therefore cover a twenty-four-year span; in addition, I note that qualified and dually qualified physicians have made both positive and negative x-ray readings for pneumoconiosis throughout the evidence of record. In light of this, and in light of the nature of pneumoconiosis as a latent, progressive disease, I will consider most probative the readings of x-rays taken within the past several years. *See Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250 (4th Cir. 2000). No x-ray evidence in the record was

[7] Claimants may also show the existence of pneumoconiosis under 20 C.F.R. § 718.202 by biopsy or autopsy evidence, neither of which exists in this claim. Twenty C.F.R. § 718.201 defines pneumoconiosis as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.

generated between 1996 and 2002, so I will consider readings of x-rays taken since 2002 to be the most probative in discovering Claimant's current medical condition.

In the recent, probative evidence, there are five readings of three x-rays (in addition to one quality-only reading). Of those readings, two from dually qualified physicians found evidence of pneumoconiosis; the remaining three readings by B-readers include one positive and two negative readings for CWP. As the best-qualified physicians have found the most recent x-rays to show pneumoconiosis in the Claimant, I find that Claimant has demonstrated that he has CWP by x-ray evidence under 20 C.F.R. §718.202(a)(1).

The Presumptions

Under 20 C.F.R. §718.202(a)(3), a miner is presumed to be suffering from pneumoconiosis if the presumptions set forth in §§ 718.304, 718.305, or 718.306 apply. Initially, I note that the Claimant cannot qualify for the § 718.304 presumption because there is no credible evidence that he suffers from complicated pneumoconiosis. Claimant does not qualify for the § 718.305 and § 718.306 presumptions because he filed his claim after January 1, 1982. Therefore, I find that Claimant has not shown that he is entitled to any of the regulatory presumptions in showing that he has CWP.

Medical Opinion Evidence

Additionally, a determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds that the miner suffers from pneumoconiosis notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a)(4)(2000). Medical reports based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an administrative law judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

In the record are fifteen medical reports from seven physicians addressing whether the Claimant has pneumoconiosis. The reports of Drs. Villanueva, Dotson, Rasmussen, and Cohen all found that Claimant had CWP. The reports of Drs. Crisalli, Zaldivar, and Weiland found the contrary. All of the reports are documented, in that their conclusions regarding the existence of pneumoconiosis in the Claimant took into account the objective testing evidence.

Dr. Villanueva found that Claimant had both "clinical" pneumoconiosis (diagnosed by x-ray) and "legal" pneumoconiosis in the form of COPD (diagnosed by PFS evidence). Dr. Dotson's three reports in the record consistently found that Claimant had both clinical pneumoconiosis by x-ray and legal pneumoconiosis in the form of an obstructive defect, as evidenced by PFS values. In his six medical reports, Dr. Rasmussen diagnosed clinical CWP by

x-ray as well as legal pneumoconiosis: chronic bronchitis by history in 1992; loss of respiratory function by PFS and ABG results in 1993; COPD based on cumulative PFS results in 1995; COPD/emphysema based on PFS results, ABG results, and reduced SBDLCO in 2002 and 2004. Dr. Cohen's 2004 report concluded that Claimant had minimal simple CWP by x-ray and legal pneumoconiosis by PFS and ABG results. I find that all of these reports are documented and reasoned in reaching their conclusions on this issue. I give more weight to the reports of Drs. Rasmussen and Cohen based on their excellent credentials and particularly strong reasoning. I also give more weight to the reports of Dr. Dotson based on his repeated and consistent examinations of Claimant that took place for more than ten years.

All three physicians who found no pneumoconiosis in the Claimant have excellent credentials that entitle their opinions to particular consideration. However, both of Dr. Zaldivar's reports are lacking in sufficient reasoning to be given much weight in this issue. Dr. Zaldivar properly relied on x-ray evidence to determine whether Claimant had CWP. However, the physician did not satisfactorily explain the nature or origin of Claimant's obstructive defect, as consistently shown in PFS results. Dr. Zaldivar plausibly attributed the obstructive defect to Claimant's past smoking habit, but in neither of his reports did he explain how he had eliminated one significant risk factor—forty-four years of coal-mine dust exposure—as a possible cause of the defect. Because Dr. Zaldivar did not address legal pneumoconiosis in his reports, I give them both little weight on this issue.

Conversely, both Dr. Crisalli and Dr. Weiland satisfactorily addressed the possibility of legal pneumoconiosis in their reports. Dr. Crisalli's report attributed Claimant's consistently abnormal PFS results to chronic bronchitis. Dr. Weiland diagnosed Claimant with moderate obstructive airways disease that, combined with Claimant's other symptoms, the physician called inconsistent with the pattern of pneumoconiosis but consistent with the symptoms of advancing age. In weighing Dr. Weiland's opinion on the issue, I also considered the opinion of Dr. Rasmussen, who unequivocally stated that Claimant's pattern of symptoms was entirely consistent with those of coal miners with low-profusion CWP nodules by x-ray. Dr. Weiland's report expressed a similar opinion. I find Dr. Rasmussen's argument on the question to be simply more persuasive, supported as it was by numerous published studies, the physician's reasoning, and Dr. Weiland's similar conclusions.

Considering all of the medical report evidence together, I find that the great weight of the evidence supports a finding that Claimant has both clinical pneumoconiosis and legal pneumoconiosis (in the form of COPD). I further observe that the most recent medical reports (since the filing of the current claim) provide the best-reasoned and best-documented evidence of the disease, a finding consistent with the tendency of CWP to be progressive in its victims. Accordingly, I find that Claimant has met his burden of establishing the existence of pneumoconiosis via the medical opinion evidence pursuant to 20 C.F.R. § 718.202(a)(4)(2000).

Weighing All Evidence Together

Pursuant to the holding in *Compton*, I must weigh all of the evidence under § 718.202(a) together in order to make a determination regarding the existence of pneumoconiosis. I found previously that Claimant has established the existence of pneumoconiosis through the chest x-ray

evidence. I found that the presumptions at § 718.202 were inapplicable to the facts in this matter. Finally, I found that the conclusions of the better reasoned medical opinions establish the existence of pneumoconiosis pursuant to § 718.202(a)(4). Accordingly, weighing all of the evidence together, I find that Claimant has established the existence of pneumoconiosis pursuant to § 718.202(a).

Cause of Pneumoconiosis

Once I have determined that a miner suffers from pneumoconiosis, I must determine whether the pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who suffers from CWP was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the disease arose out of such employment. 20 C.F.R § 718.203(b).

I find that Claimant, with forty-four years of coal mine employment, is entitled to the rebuttable presumption at § 718.203. The Employer/Carrier has not produced sufficient evidence to rebut this presumption. The Claimant has therefore demonstrated that his CWP arose, at least in part, from coal-mine employment pursuant to the Act.

Total Disability

Total disability is defined as pneumoconiosis preventing a miner from performing his usual coal mine employment or other gainful work. 20 C.F.R. §§ 718.305(c), 718.204(b)(1). Section 718.204 sets out the standards for determining total disability. This section provides that in the absence of contrary probative evidence, evidence that meets the quality standards of the subsection shall establish the miner's total disability.

The PFS evidence as a whole supports a finding of total disability in the Claimant. Although the older PFS results, obtained from 1980 through 1995, do not conform to the more recent studies that demonstrate disability, I find the more recent evidence to be more probative because it better reflects the miner's current condition. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993). All of the studies conducted since 1996 produced qualifying results. In addition, Claimant's PFS results show a consistent pattern of deterioration from 1980 to 2004. I find that the PFS results overall demonstrate that Claimant is totally disabled from a respiratory standpoint. 20 C.F.R. § 718.204(b)(2)(i).

The Claimant can also demonstrate total disability with qualifying blood-gas study results. Of the six ABG studies in evidence, only one produced qualifying results under § 718.204(b)(2)(ii). The most recent tests, both drawn in 2002, tend to show total disability, as I found above. However, the overall ABG evidence is heavily against a showing of total disability. I find that Claimant has not demonstrated his disability by ABG results under the Regulations.

Claimant's third option to show total disability is to present evidence that he suffers from cor pulmonale with right-sided congestive heart failure. 20 C.F.R. § 718.204(b)(2)(iii). Because

Claimant has produced no evidence that he suffers from this condition, I find that he has not shown disability by this method.

Finally, Claimant may show total disability by presenting the reasoned opinion of a physician who, exercising reasoned medical judgment based on medically acceptable clinical and laboratory diagnostic techniques, concludes that Claimant's respiratory or pulmonary condition prevents him from engaging in his last or comparable employment. 20 C.F.R. § 718.204(b)(2)(iv). In addition to the new medical reports in evidence, I also consider the following reports that address disability:

- Dr. Rasmussen, 1/27/92, DX-1
- Dr. Rasmussen, 7/21/93, DX-1
- Dr. Dotson, 9/17/93, DX-1
- Dr. Rasmussen, 4/10/95, DX-1
- Dr. Zaldivar, 4/30/96, DX-1
- Dr. Weiland, 4/14/97, DX-1)

Of the eleven reports that express an opinion about Claimant's ability to perform his former coal-mine work, eight conclude that Claimant is totally disabled, while three find the contrary.

Dr. Rasmussen's first examination of the Claimant in 1992 concluded that the miner was not totally disabled by the CWP that the physician found in him. However, one year later, the physician found that Claimant's pulmonary condition had declined to the point that he was no longer able to perform his last coal-mine job. All of Dr. Rasmussen's reports since that time have maintained this opinion. Every one of Dr. Rasmussen's reports in evidence is well-reasoned and well-documented on the issue of Claimant's disability, and I accord this physician's opinion great weight in my considerations.

Dr. Dotson, whose opinions I have given added weight based on his regular and longstanding relationship to the miner, found Claimant to be disabled by pneumoconiosis in 1993 and has maintained that opinion in his ensuing reports. All of these reports give due consideration to the objective evidence of record and provide satisfactory reasoning for the physician's results. I therefore find that Dr. Dotson's conclusions on this issue are entitled to considerable weight in my determination.

Dr. Zaldivar's report of 1996 concluded that Claimant was not totally disabled; in 2003, the physician concluded that Claimant was disabled by age and deconditioning, although not by CWP. The more relevant of the two reports for determining Claimant's current condition is the latter, as all of the physicians of record with multiple medical reports have detected a decline in Claimant's overall medical condition. As I found previously, the 2003 report was neither well-reasoned nor well-documented, and I give it little weight in my considerations.

Dr. Weiland submitted a consultation report in 1997, having considered Claimant's medical history by reading the reports contained in his Black Lung benefits file. The physician found that Claimant had the pulmonary ability to perform his last coal-mine job. Although Dr.

Weiland's report is brief and provides little reasoning, I find that it is sufficiently documented and reasoned to be considered on this issue and I give it some weight.

As I discussed previously, Dr. Cohen's finding of total pulmonary disability in the Claimant is reinforced by the physician's excellent credentials, solid reasoning, and the documentation he cites. I give Dr. Cohen's report great weight in my determination of this issue.

Looking at all the medical report evidence together, and keeping in mind that the reports' relevance increases with their proximity to the hearing date (as they tend to show more effectively the miner's current medical condition), I find that Claimant has demonstrated disability in this manner. The overwhelming weight of the recent and better-reasoned reports supports this finding.

Claimant has shown through both PFS evidence and reasoned medical reports that, pursuant to § 718.204(b)(2)(iv), he is totally disabled from a respiratory standpoint as defined by the Regulations.

Disability Causation

The final issue is whether Claimant has established disability causation pursuant to § 718.204(c)(1). That subsection states that a miner is considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
(ii) Materially worsens a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine employment.

In addition, pursuant to § 718.304, there is an irrebuttable presumption that the miner's disability is due to coal-mine employment if he suffers from complicated pneumoconiosis. An X-ray showing a large opacity that is categorized as size A, B, or C demonstrates complicated pneumoconiosis. 20 C.F.R. § 718.304(a). As no credible evidence of complicated pneumoconiosis exists in evidence, I find that Claimant has not shown that he suffers from complicated pneumoconiosis and is not entitled to the presumption at § 718.304.

To make my determination on this issue, I consider the eight medical reports that discussed disability causation. Five of those reports were written by Dr. Rasmussen, two by Dr. Zaldivar, and one by Dr. Cohen. All of Dr. Rasmussen's reports concluded that Claimant's disability arose primarily from his coal-mine dust exposure, although the physician opines that Claimant's previous smoking habit might also have made some contribution. Dr. Cohen's findings in his report were the same—that Claimant's coal-mine work caused his disability for the most part, although his smoking may have made a minimal contribution. On the other hand, Dr. Zaldivar concluded in one report simply that Claimant's pulmonary impairment was non-

occupational, in the other that his disability was due to age and deconditioning. I found Dr. Rasmussen's and Dr. Cohen's explanations to be more plausible, better explained, and more consistent with the findings I have made in this Decision. I therefore find that the Claimant has shown, by a preponderance of the evidence, that his clinical and legal pneumoconiosis are the cause of his total pulmonary disability pursuant to § 718.204(c)(1).

Conclusion

Because Claimant has shown a material change in condition since the denial of his former claim, and because Claimant has satisfied his burden in showing all elements of entitlement, I find that he is entitled to benefits under the Act. Pursuant to 20 C.F.R. § 725.503, I observe that the evidence shows no date of onset of total disability, so benefits shall be payable from the first day of the month during which Claimant filed this claim, which was January 26, 1999. Claimant's benefits are therefore payable beginning January 1, 1999.

Representative's Fees

No award of representation fees for services to Claimant is made herein, as no application has been received. Thirty days are hereby allowed to Claimant's representative for the submission of such application. His attention is directed to 20 C.F.R. §§ 725.365 and 725.366 of the Regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of Orval King for benefits under the Act is hereby GRANTED. The responsible operator, Flat Top Colliery Corporation, shall pay to the Claimant all benefits to which he is entitled, commencing January 1, 1999.

A

MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty days of the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution